Nos. 02-1845 and 03-83

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IN THE

Supreme Court of the United States

No. 02-1845

AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

No. 03-83

CIGNA HEALTHCARE OF TEXAS, INC. and CIGNA CORPORATION,

Petitioners,

v.

RUBY R. CALAD,

Respondent.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF IN OPPOSITION TO PETITIONS FOR A WRIT OF CERTIORARI OF AETNA HEALTH, INC. AND CIGNA HEALTHCARE OF TEXAS, INC.

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QUESTION PRESENTED

Finding support in *Pegram v. Herdrich*, 530 U.S. 211 (2000), did the Fifth Circuit correctly hold that a state-law tort claim arising out of an HMO's mixed coverage and treatment decision is not completely preempted by section 502(a)(1)(B) of ERISA (29 U.S.C. § 1132(a)(1)(B))?

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Respondents Juan Davila and Ruby Calad file this consolidated response in opposition to the petitions for writ of certiorari filed by their respective health-maintenance organizations, Aetna Health Inc. (No. 02-1845), and CIGNA HealthCare of Texas, Inc. (No. 03-83).

STATEMENT OF JURISDICTION

This Court has jurisdiction under 28 U.S.C. § 1254(1). But whether the district court had jurisdiction under 28 U.S.C. § 1331—something the petitioners proffer as fact (Aetna, CIGNA Pet.'s at 1)—was actually decided in the negative by the Fifth Circuit. As a result, the assertion of these two HMOs that the district court "had jurisdiction" under both 28 U.S.C. § 1331 and the "complete preemption effected by 29 U.S.C. § 1132" is a characterization with which the appellate court disagreed (and which is the core issue here)—hence the judgment directing a remand to state court.

INTRODUCTION

Reversing the district courts' separately reached conclusions that they had jurisdiction over Davila's and Calad's state-law tort claims under ERISA § 502(a)'s complete-preemption doctrine, the Fifth Circuit held that those claims neither duplicated nor fell within the scope of a section 502(a)(1)(B) claim. According to the appellate court, Davila's and Calad's motions to remand their respective cases should have been granted, and the district-court judgments were therefore reversed.[1]

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1. If this Court either denies the petitions or affirms the Fifth Circuit on the merits, the Texas state courts will (undoubtedly) then be called upon to decide whether Davila's and Calad's claims

(Cont'd)

Drawing principally from an analysis of *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), and *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002)—an analysis further informed by *Pegram v. Herdrich*, 530 U.S. 211 (2000)—the Fifth Circuit concluded that Davila's and Calad's tort claims against the HMOs for the latter's mixed eligibility and treatment decisions differed substantively from the essentially contract-based benefit claims for which ERISA § 502(a)(1)(B) provides the exclusive remedy. (Aetna App. at 16a – 20a.)

That is, a state-law tort claim that an HMO's mixed eligibility and treatment decision caused personal injury to an HMO member is so unlike an ERISA § 502(a)(1)(B) claim to "recover benefits" due under an ERISA plan that the field preemption Congress intended with ERISA simply does not come into play.

(Cont'd)

are nonetheless to be dismissed due to ERISA § 514 conflict preemption, a purely defensive matter not conferring removal jurisdiction. *See Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 23-27 (1983). Because section 502(a) complete preemption is very different from section 514's "relates to" preemption, the most efficient course seems to be for the Court to grant the petition in *Roark v. Humana, Inc.*, No. 02-1826 (pet. docketed June 17, 2003), a case dealing squarely with the broader question of whether ERISA § 514 preempts a state medical-negligence claim. (The Fifth Circuit consolidated *Roark*, *Davila*, and *Calad* for argument, and the opinion below resolved all three cases.) Aetna has asked for just the opposite approach: that the *Roark* petition be held until its petition here has been ruled on. (Brief for Respondent Aetna Health Inc., filed in *Roark*, No. 02-1826.) The undersigned, as counsel for Roark, will be filing a reply opposing that suggestion as having it backward, from the standpoint of both efficiency and logic.

Despite Aetna's and CIGNA's dramatic pronouncements,[2] this holding is not a radical departure from this Court's precedent; it does not conflict with controlling Supreme Court authority; and it does not conflict with the views of any other circuit on this precise issue.[3] Indeed, the decision below independently tracks that of the Second Circuit in *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, No. 01-9248 (U.S. July 11, 2003); and most recently, the Eleventh Circuit has joined in recognizing that the concept of HMOs' "mixed" decision-making, rightly considered in light of *Pegram*, yields a much more accurate understanding of what section 502(a)(1)(B) really means. *Land v. CIGNA Healthcare of Florida*, __ F.3d __, No. 02-15549, 2003 WL 21751247 (11th Cir. July 30, 2003).

In short, this Court need not grant Aetna's or CIGNA's petitions, for any purported conflict is illusory. Respondents do agree that the whole area of ERISA preemption is of great importance, particularly in its recurring forms, but contend that if the Court were to grant the petition instead in *Roark v. Humana*, No. 02-1826, and reverse the Fifth Circuit's holding in that case, a broader—and thus more likely final—word on section 514 "relates to" preemption would put to rest much of the current uncertainty, as it would necessarily resolve the narrower section 502(a)(1)(B) issue here involved.

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2. *E.g.*, Aetna claims that the Fifth Circuit has "categorically exempt[ed] state tort actions from complete preemption" (Aetna Pet. at 9), when in fact nothing of the sort has occurred.

3. The circuit-court cases cited by petitioners may be superficially at odds with the Fifth Circuit's holding, but they are readily distinguishable, as Respondents will show.

STATEMENT OF THE CASE

If the Court grants the petitions and receives briefing on the merits, the respondents will provide a more detailed factual recitation. For purposes of opposing the petitions and providing the necessary background for the Court to consider the Fifth Circuit's holding, the respondents proffer the following:

Juan Davila

Davila's employer, Monitronics, set up an ERISA employee-benefit plan, which in turn contracted with Aetna for its employees' health coverage. (Aetna App. at 67a, 85a.) Aetna—not Davila's employer or that employer's ERISA plan—created a drug formulary that included Vioxx. (Aetna App. at 67a.) Though Davila's treating physician prescribed Vioxx to alleviate this post-polio diabetic's arthritis pain, Aetna required Davila's treating physician to first place him in a "step program" under which Davila had to try two (cheaper) medications and either suffer an adverse result or show no improvement before Aetna would pay for a Vioxx prescription. (Aetna App. at 67a – 68a.)

Davila in fact suffered an adverse reaction to naprosyn, one of the cheaper drugs that has been shown to have a higher incidence of gastrointestinal bleeding and ulceration than Vioxx: after being rushed to the emergency room, doctors discovered that Davila suffered from bleeding ulcers that resulted in a near heart attack. The emergency-room doctors told Davila that he was only hours away from dying of internal bleeding, and he can no longer take any pain

medication that has to be absorbed through the stomach. (Aetna App. at 68a.)

By referring often to an "ERISA plan" and to Aetna's "Certificate of Coverage," Aetna's statement of the case attempts to cast this situation as one involving nothing more than a coverage dispute rather than, as the Fifth Circuit concluded, one that plainly had components of both coverage (eligibility) *and* treatment decisions.[4]

Ruby Calad

As did Aetna, Calad's HMO (CIGNA) made decisions with both coverage and treatment components when its discharge nurse declined to approve the request of Calad's treating surgeon that she be allowed to stay in the hospital for more than one day following a hysterectomy with rectal, bladder, and vaginal repair. (Aetna App. at 3a.) Calad was sent home, where she suffered complications that led to her emergency readmission to the hospital a few days later. (*Id.*)

And as it did with Aetna, the Fifth Circuit concluded that CIGNA's "mixed" decision featured "the type of 'when and how' medical necessity questions . . . that fall within *Pegram*'s rule." (Aetna App. at 14a.)

Both Davila and Calad sued under the Texas Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE §§ 88.001 – 88.003 (Aetna App. at 56a – 63a), a statute that creates a cause of action against HMOs (among others) for damages

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4. "It seems beyond dispute that . . . Davila's claims involve such mixed decisions. . . . Aetna agrees its plan includes a range of arthritis drugs, so we are not presented with simple yes-or-no coverage questions." (Aetna App. at 13a – 14a.)

caused by a failure to use ordinary care in making health-care treatment decisions.[5]

REASONS FOR DENYING THE PETITIONS

The opinion below is consistent with this Court's precedent.

Careful examination of this Court's prior cases dealing with ERISA § 502(a) reveals that the Fifth Circuit correctly recognized that a contract–tort distinction is both appropriate and in keeping with ERISA's purposes. As this Court has held, it is ERISA's "repeatedly emphasized purpose to protect contractually defined benefits." *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985); *accord Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (reiterating ERISA's focus on contractually defined benefits).

In contrast (and as the Second Circuit noted in *Cicio*, 321 F.3d at 99-100), state medical-malpractice law, "even if implicated by the execution of a benefits decision," *id.*, involves duties that exist and are defined independent of ERISA plans and thus cannot be counted among the "rights and expectations brought into being by [ERISA]," *Ingersoll-Rand*, 498 U.S. at 137, rights that section 502(a) was designed to protect.

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5. "Health care treatment decision" is defined in the THCLA as "a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." TEX. CIV. PRAC. & REM. CODE § 88.001(5) (Aetna App. at 56a). "Ordinary care," as applied to an HMO, means "that degree of care that . . . [an HMO] . . . of ordinary prudence would use under the same or similar circumstances." Section 88.001(10) (Aetna App. at 57a).

Petitioners' touchstone for the contrary proposition is *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), a case that involved a claim for improper processing of disability benefits. Principally a decision that ERISA § 514 preempts any contract and state-law bad-faith tort claims, and, secondarily, that ERISA § 502(a) provides the exclusive vehicle for redressing all such claims, *Pilot Life* does not resolve, or even address, the present issue: what are the boundaries of the term "benefits" that appears in section 502(a)(1)(B), in the context of medical treatment? Or, as the question might be framed here, are "benefits" limited to an obligation to pay for contractually defined services, or do "benefits" include an externally mandated medical standard of ordinary care under state law, which Congress somehow intended for ERISA to usurp?

In reading "benefits" to subsume only the former, and in keeping with this Court's precedents, the Second Circuit aptly summarized the distinction in a passage worth repeating in its entirety:

> Even if, absent a benefits contract, no medical care would in fact have been furnished, so that the medical judgment in one sense is a "benefit" and a direct consequence of the exercise of a contractual right, the state law obligation to provide care of a given level of quality when providing care is nonetheless distinct from the contract. (*Cicio*, 321 F.3d at 100, n.11.)

That conclusion is consistent not only with *Pilot Life* but also with *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), in which the Court again held that section 514

preempted state-law claims arising out of the denial of disability benefits, including a related claim of retaliatory discharge, and that the remedies found in section 502(a) create removal jurisdiction.[6]

The distinction between contract-based duties that section 502(a) was designed to protect and those here involved under Texas health-care law is not undercut, despite Aetna's argument, by *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (discussed at pp. 14-16 of Aetna's petition). There, the plaintiff sued in state court under a wrongful-discharge theory that his employer fired him to avoid having to pay pension benefits. Not surprisingly, this Court found that claim preempted under section 514, largely because it could not exist without reference to an ERISA plan (". . . this cause of action relates not merely to pension benefits, but to the essence of the pension *plan* itself," *id.* at 140 (emphasis in original)).

Only *after* finding section 514 preemption did the Court turn to its secondary holding: that even without section 514 preemption, the state-law claim would be preempted because it conflicted directly with an ERISA cause of action, set out in section 510 and enforceable through section 502(a).[7]

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6. The fact that, in both *Pilot Life* and *Metropolitan Life*, the Court began its analysis with section 514 and only afterward moved on to a section 502(a) discussion further militates in favor of considering the petition in *Roark v. Humana, Inc.*, a section 514 decision, before considering Aetna's and CIGNA's petitions. (The same analytical pattern appears in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990).)

7. ERISA § 510 expressly makes it unlawful, among other things, to fire someone in order to interfere with a right to which he might be entitled under an ERISA plan. 29 U.S.C. § 1140.

In other words, because the Texas claim *duplicated* one that ERISA already provided (even though the remedies differed), the state claim had to yield to ERISA's preemptive force. *See also Egelhoff v. Egelhoff*, 532 U.S. 141 (2001) (finding preempted a Washington state statute governing distribution of life-insurance proceeds to former spouses, where that statute directly conflicted with an ERISA provision on the same subject; "unlike generally applicable laws regulating '*areas where ERISA has nothing to say*,' . . . which we have upheld notwithstanding their incidental effect on ERISA plans, . . . this statute governs the payment of benefits, a central matter of plan administration." [*Id.* at 147; emphasis added]). Plainly, ERISA has "nothing to say" about medical standards of ordinary care, a topic left entirely to the states.

Although the petitioners scoff at the Fifth Circuit's holding that only a claim duplicating an existing one under ERISA is properly preempted under section 502(a), in fact that holding finds support as recently as last year, when the Court decided *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002). In that case, the Court correctly noted that since *Pilot Life*, it has found only one other state law (the one involved in *Ingersoll-Rand*) to "conflict" with section 502(a) "in providing a prohibited alternative remedy." *Id.* at 379. As the Court explained *Ingersoll-Rand*,

> . . . while state law duplicated the elements of a claim available under ERISA [*i.e.*, a section 510 claim], it converted the remedy from an equitable one under [section 502(a)(3)] (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal).

Id.

Nothing about the Fifth Circuit's decision below conflicts with this or any other binding authority, for the simple reason that *no* case from this Court has confronted, in the section 502(a)(1)(B) context, whether a state-law claim rooted in a duty beyond that to properly process a claim for ERISA benefits "falls within the scope" of section 502(a). *See Metropolitan Life*, 481 U.S. at 64. Aetna's statement, at page 12 of its petition, that "any suit *touching the same subject matter* becomes a Section 502(a) claim" (emphasis added) thus incorrectly conflates section 514's "relates to" provision with the much narrower question of whether a state-law medical-malpractice claim is one that falls under section 502(a)(1)(B) in the first instance.

And to further understand the correctness of the Fifth Circuit's decision, the state-law claims found to be subsumed within section 502(a) in both *Pilot Life* and *Metropolitan Life* must be distinguished from what a state may properly regulate wholly independently of ERISA. Though understandably (but somewhat disingenuously) neither Aetna nor CIGNA mentions it, this Court has in recent years consistently recognized that the field of health care is a "subject of traditional state regulation, [and] there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (citing *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Inc. Co.*, 514 U.S. 645, 654-55 (1995).[8]

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8. *See also California Div. Of Labor Standards Enforcement, N.A., Inc. v. Dillingham Constr.*, 519 U.S. 316, 330 (1997) (there must be an "indication in ERISA . . . [or] its legislative history of [an] intent on the part of Congress to preempt a traditionally

(Cont'd)

Though the Court's retrenchment from the virtually limitless view of ERISA preemption that inhered when it decided *Pilot Life* and *Metropolitan Life* came about in the context of section 514, the analysis is of critical importance to a proper view of what kinds of disputes about "benefits" fall within the scope of section 502(a)(1)(B). That view is significantly circumscribed by *Pegram*, even though *Pegram* was not a preemption case, because the Court has now drawn a clear distinction between purely administrative decisions (such as whether a particular contract *covers* a particular condition or treatment), and the far more common ones that involve both a coverage and a treatment decision.

In *Pegram*, Lori Herdrich complained that her health-care provider, a group of doctors who could earn bonuses through their physician-owned HMO by minimizing the amount of care and by referring patients only to facilities controlled by the group, breached its fiduciary duty under ERISA by having such an arrangement. The Court disagreed, holding that a physician's delaying needed treatment to save money for the HMO and to increase the physician's compensation did not breach ERISA's fiduciary-duty provisions.

(Cont'd)

state-regulated substantive law"; "if ERISA were concerned with any state action—*such as medical-care quality standards. . .*—that increased the costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we would scarcely see the end of ERISA's pre-emptive reach" [emphasis added]); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813-14 (1997) ("[H]istoric police powers of the State [which the Court assumes ERISA was not meant to supersede] include the regulation of matters of health and safety.").

Pegram is a logical extension of the *Travelers–De Buono–Dillingham* trilogy, which established that ERISA's preemptive reach was not so broad as earlier thought. According to *Pegram*, recognizing an ERISA fiduciary-based remedy for what is essentially a state-law medical-malpractice claim would entail a federalized standard of reasonable medical care and "raise a puzzling issue of preemption":

> On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state-law malpractice claim. *See* 29 U.S.C. § 1144 (preempting state laws that "relate to [an] employee benefit plan").

530 U.S. at 236.

But noting that *Travelers* "throws some cold water on the preemption theory," the Court summed up that case's core holding: "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.* at 237. (And, manifestly, nothing in ERISA suggests that Congress intended to preempt state-law regulation of medical decision-making, even in the guise of "medical necessity.")

Importantly, the health-care issues before the Court in *Pegram* were ones found to be "inextricably mixed": administrative, coverage-type decisions (always preempted) and pure treatment decisions (the subject, most plainly, of state malpractice laws):

> It will help to keep two sorts of arguably administrative acts in mind. *Cf. Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (C.A.3 1995) (discussing dual medical/administrative roles of HMOs). What we call pure "eligibility decisions" turn on the plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about *how* to go about diagnosing and *treating* a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?

530 U.S. at 228 (emphasis added).

The Court then concluded that Herdrich's complaint raised "just such mixed eligibility and treatment decisions." *Id.* at 229. Juan Davila's and Ruby Calad's claims do, too: instead of allowing their doctors to determine how they should be treated, Aetna and CIGNA took upon themselves the role of deciding the "appropriate medical response," even though, respectively, Vioxx was on the Aetna formulary, and CIGNA covered hospitalizations for surgeries such as hysterectomies.

In the next section of the *Pegram*, the Court opined that Congress "did not intend" for an HMO to be considered a fiduciary "to the extent that it makes mixed eligibility decisions acting through its physicians. We begin with doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature." 530 U.S. at 231.

A finding of no fiduciary status with regard to medical-necessity decisions is tantamount to a broader finding that ERISA does not preempt other types of claims arising from such decisions; *Pegram*'s holding and reasoning, especially

when coupled with the Court's recently developed and consistent view that Congress did not intend ERISA to preempt a subject of traditional state regulation such as health care, lead logically to just such a result. And that is exactly what the Fifth Circuit concluded:

> Any doubts we might have [about holding that § 502(a)(1)(B) preempts only duplicative causes of action] are eliminated by *Pegram*'s admonition that ERISA should not be interpreted to preempt state malpractice laws or to create a federal common law of medical malpractice. *See Pegram*, 530 U.S. at 236-37. We decline, two years after the Court expressed disbelief that Congress would federalize medical malpractice law under § 502(a)(2), to hold that Congress has done so under § 502(a)(1)(B).

Aetna App. at 20a.

In short, the Fifth Circuit, far from ignoring or flouting this Court's precedent, has issued an opinion that flows logically from *Pilot Life* up to the present.

There is no circuit split—indeed, post-*Pegram *decisions from two other circuits considering this issue are in accord with the Fifth Circuit.

Aetna and CIGNA strive to posit a circuit split on whether state medical-malpractice claims against an HMO are completely preempted by section 502(a). But the cases on which they rely are distinguishable either because they did not involve a state medical-malpractice claim (or really

did involve purely administrative decisions), or because they pre-date *Pegram* (or fail to consider its import).

But before distinguishing the petitioners' cases, Davila and Calad would note that the Fifth Circuit has now been joined in its essential holding by the only two other circuits to confront this precise issue after *Pegram*.

In *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, No. 01-9248 (U.S. July 11, 2003), the magistrate judge had found that section 502(a) completely preempted all the plaintiff's state-law claims, including one for medical malpractice. (The district court adopted the magistrate's report in its entirety.) The Second Circuit affirmed that conclusion and consequent dismissal of two of the claims, but reversed as to the medical-malpractice claim.

Carmine Cicio was covered under an HMO plan that limited the HMO to providing only "medically necessary" services. The plan further provided that the HMO was not obligated to cover any treatment that, in the HMO medical director's judgment, was experimental or not generally recognized for the condition in question.

After Cicio's cancer did not respond to initial therapies, his treating oncologist requested that the HMO approve treatment with high-dose chemotherapy coupled with a double stem-cell transplant. The HMO decreed that such transplants were experimental and denied the request. The oncologist responded with an explanation of this "well-established method of treatment" (321 F.3d at 88), together with citations to pertinent medical literature. The HMO again

refused the request to approve a double transplant; less than two months later, Mr. Cicio died.

His widow sued the HMO in state court, alleging medical malpractice and other state-law claims. After the HMO removed the case, the district court dismissed the complaint based on ERISA § 502(a) preemption, concluding that Mrs. Cicio sought a remedy that would involve enforcing the terms of an employee-benefit plan.

The Second Circuit reversed in part. It first held that Mrs. Cicio's claim of "untimeliness," based on a New York statute that imposed a shorter period than do certain ERISA regulations for handling an appeal of a denial of care, was completely preempted as "an alternative mechanism . . . for enforcing the rights protected by ERISA." *Id.* at 95 (internal citations omitted). The Second Circuit also held that a state-law claim of misrepresentation was similarly "within the scope of § 502(a)" *id.* at 94 (citing *Metropolitan Life v. Taylor*, 481 U.S. at 66), because it sought to "vindicate rights accruing under the plan." *Id.* at 96. As a result, the HMO's removal was proper, and the district court had jurisdiction (unlike in Davila's and Calad's cases, but like Roark's).

Because section 502(a) created jurisdiction over those aspects of Cicio's claims, the Second Circuit's consideration of the medical-malpractice claim went straight to conflict preemption under section 514: "The question [is] whether a state law medical malpractice claim brought with respect to a medical decision made in the course of prospective utilization review by a managed care organization or health insurer is preempted under ERISA § 514, and therefore beyond the reach of state tort law. . . ." *Id.* at 98.

Though recognizing that earlier cases from other circuits had been decided oppositely, the Second Circuit concluded that, based on *Pegram*, the mere fact that a particular health-care decision contains an administrative (eligibility) component "no longer has determinative significance for purposes of preemption analysis when the decision also has a medical component." *Id.* at 103.[9]

In addition to its lengthy discussion of *Pegram*, several features of *Cicio* are noteworthy here. First, the Second Circuit pointed out that ERISA's "repeatedly emphasized purpose [is] to protect *contractually* defined benefits." *Id.* at 99 (quoting *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985); emphasis in *Cicio*). By contrast, state medical-malpractice law "involves the application of duties of conduct that are defined independent of ERISA plans." *Id.*

Second, the court noted its "skepticism" of reasoning that would draw from a statute meant to protect employees "the elimination of protective standards of professional conduct." *Id.* at 103-04. The court thus saw

> no reason . . . to bar as preempted state law malpractice actions that rest on the application of

9. The Ninth Circuit might be aligning itself with the Second Circuit, although the exact question has not arisen. *See Roach v. Mail Handlers Benefit Plan*, 298 F.3d 847 (9th Cir. 2002) (citing both *Rush Prudential* and *Pegram* and holding that Federal Employees Health Benefits Act (FEHBA), which contains preemption language similar to ERISA, did not preempt pure medical-malpractice claim brought by a FEHBA participant against her plan; claim was not a preempted denial-of-benefits claim). *See also Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842 (Fla. 2003) (citing *Cicio* approvingly in the course of holding that ERISA § 514 did not preempt plaintiff's vicarious-liability claim against HMO).

> standards for medical decision-making—which are established by states *independent of and prior to health benefits contracts*—to "a patient's constellation of symptoms."

Id. at 104, quoting *Pegram*, 530 U.S. at 228 (emphasis added).

Though *Cicio*'s analysis proceeded under section 514, it necessarily means that the medical-malpractice claim was not preempted under section 502(a), since the latter is simply a subset of the former. In other words, as the Fifth Circuit put it in the decision below, "any claim that falls within § 502(a) necessarily falls within § 514. . . ." (Aetna App. at 15a, n.11.)

In a case most procedurally akin to Davila's and Calad's, last month the Eleventh Circuit conducted a section 502(a)(1)(B) analysis of state medical-malpractice claims, found them not completely preempted, and directed a remand to state court. *Land v. CIGNA Healthcare of Florida*, __ F.3d __, No. 02-15549, 2003 WL 21751247 (11th Cir. July 30, 2003).

There, an HMO nurse overrode two physicians' collective decision that Robbie Land should be hospitalized in order to receive intravenous antibiotics for a serious infection. After being treated on an out-patient basis for several days, Land's condition worsened considerably, and he ultimately had to have the infected finger amputated. Land sued CIGNA in state court for medical negligence, and CIGNA removed to federal court based on section 502(a).

In its analysis, the Eleventh Circuit recognized that the first step was to determine whether Land's claims fell within the scope of one of the three categories of section 502(a)(1)(B). Easily ruling out a construction of the claims as involving seeking "to clarify his rights to future benefits" or "to enforce his rights under the terms of [his health care] plan," the court was left to consider whether the claims were ones "to recover benefits." 2003 WL 21751247 at *3. In that regard, the court relied heavily on *Pegram*, concluding after extensive discussion that the CIGNA nurse had made a "mixed" eligibility and treatment decision because rather than being a "simple yes-or-no eligibility determination about whether CIGNA would cover treatment for cellulitis," the eligibility decision was instead "intertwined with the approval nurse's *medical* decision that inpatient treatment of Land's infection was unnecessary." *Id.* at *5 (emphasis added).

Having reached that stage in the analysis, the *Land* court then turned to the final inquiry: Are mixed-decision claims ones "to recover benefits" under section 502(a)(1)(B) and therefore completely preempted? Once again, the Eleventh Circuit found *Pegram*'s reasoning persuasive.

Citing that portion of *Pegram* in which this Court expressed strong doubt that Congress meant to federalize and preempt state malpractice claims by transmuting them into section 502(a)(2) fiduciary claims or to "apply[ ] an ERISA standard of reasonable medical skill," 530 U.S. at 236, the Eleventh Circuit—in a conclusion virtually identical to that reached by the Fifth Circuit here—found that

> . . . it makes little sense to believe that Congress did not intend to federalize malpractice claims

> under section 502(a)(2), but intended to do so under section 502(a)(1)(B).

2003 WL 21751247 at *6.

The *Land* court also noted its own precedent that viewed section 502(a)(1)(B) claims as "essentially . . . contract claims." *Id.* (citing cases). And because Land neither alleged that he was denied medical benefits nor sought reimbursement of medical expenses, but instead claimed that his personal injuries resulted from CIGNA's "failure to diagnose his condition correctly and authorize the proper medical treatment," his claims were "tort claims based upon the duty of care rather than contract claims based solely upon a denial of benefits." *Id.* For that reason, the court found CIGNA's reliance on *Pilot Life* to be "misplaced": "As we do not believe that Land's malpractice action is based solely upon the improper processing of a claim, *Pilot Life Insurance Co.* does not foreclose our holding in this case. " *Id.*, n.5.

Cicio and *Land* deal directly with the controlling issue here. The cases cited by Aetna and CIGNA do not, and therefore no circuit split exists.

The lead-off "contrary" case in both petitions is *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003), which Aetna characterizes as "reaffirm[ing] that plaintiffs may not circumvent Section 502(a)'s exclusivity by bringing state-law claims relating to *benefits administration*—however cleverly those claims might be characterized." (Aetna Pet. at 20 [emphasis added].) That statement of the law is unassailable—but neither the legal principle nor the facts of *Marks* have much to do with Davila's and Calad's claims.

There, it was the sheer factual deficiencies in the plaintiff's claims against the decedent's PPO's subcontractor as much as anything that resulted in a holding of section 502(a) complete preemption. The decedent (who, following his discharge from in-patient psychiatric care, murdered his wife and child and then killed himself) was a member of a preferred-provider organization ("PPO"), not an HMO. That PPO subcontracted with another company to perform utilization-review and other administrative services.

It was undisputed that the subcontractor, Mainstay, had no input into or involvement whatsoever in the decedent's medical treatment; the decedent's treating physicians never spoke with Mainstay's employee (the named defendant, Watters); the decision to discharge the decedent from in-patient care was made *solely* by the physicians, with no pressure from or discussion with Mainstay; and Mainstay's employee was told by the hospital of "medical treatment decisions and diagnoses only after the doctors had *already* made them." *Id.* at 326 (emphasis in original).

Not surprisingly, on these facts the Fourth Circuit rejected the plaintiff's attempt to argue that Mainstay somehow made a "mixed" decision that incorporated some treatment component (an argument made to try to bring the claims within *Pegram*'s reasoning, since purely administrative decisions are of course completely preempted). As the *Marks* court held, a plaintiff

> cannot transform what is properly considered a § 502(a) claim into a state-law claim for malpractice simply by making *unsubstantiated and incorrect* statements that an independent

> utilization review agent was responsible for medical decisions.

Id. at 326 (emphasis added).

As a result of these clear factual inadequacies, the *Marks* court never had to reach the issue of whether, if Mainstay's conduct *had* included a treatment component, the "mixed" nature of the decision-making would, consistent with *Pegram*'s implications, take the case out of section 502(a)'s preemptive ambit.

Just as *Marks* thus sheds little light on the issue on which the Fifth, Second, and Eleventh Circuits have now shown a united front, neither do Aetna's and CIGNA's other cases. Without going into a detailed discussion of each of them, all but one of the post-*Pegram* cases did not even assert claims involving state health-care standards or medical malpractice—a particularly immaterial category since the states are empowered to regulate such matters, thus making *Pegram* (and the trilogy) a critical piece of the preemption puzzle. Petitioners' post-*Pegram* cases not involving a health-care-related claim are these:

- *Fink v. Dakotacare*, 324 F.3d 685 (8th Cir. 2003) (state-law claims for breach of contract, unfair trade practices, and unspecified torts arising out of insurer's denying claim for COBRA continuation benefits under former employer's group health plan held completely preempted);

- *Conover v. Aetna U.S. Healthcare, Inc.*, 320 F.3d 1076 (10th Cir. 2003) (bad-faith claim arising out of administration of disability benefits completely preempted);

- *Howard v. Coventry Health Care of Iowa, Inc.*, 293 F.3d 442 (8th Cir. 2002) (per curiam) (claims for breach of contract, tortious breach of statute, and bad faith preempted under section 514);

- *Hotz v. Blue Cross and Blue Shield of Massachusetts, Inc.*, 292 F.3d 57 (1st Cir. 2002) (state statutory claim permitting damages and attorney's fees for unfair or deceptive acts or practices in conduct of trade or commerce completely preempted).[10]

The petitioners' only other case that post-dates *Pegram* is *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), in which the Third Circuit held, unremarkably, that a claim of HMO liability for delay in approving a referral to an out-of-network provider involved a purely administrative decision that was thus completely preempted.

A number of Aetna's remaining cases[11] pre-date *Pegram* and accordingly are of even more questionable utility. (Three

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10. Aetna's discussion of *Hotz* misleadingly intimates that the plaintiff's "attack on a pre-approval decision" that "allegedly caused the plaintiff's cancer to worsen" (Aetna Pet. at 22) had something to do with a state malpractice or health-care-related claim, when no such claim was advanced. Thus, Aetna's applauding the Eighth Circuit for "not [being] distracted . . . by *Pegram*'s elaboration [of eligibility, treatment, and mixed decisions]" is false flattery: nothing about the plaintiff's unfair-trade-practices claim would have logically brought *Pegram* into the discussion.

11. *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072 (8th Cir. 2000) (per curiam) (case did not even discuss *Travelers* trilogy); *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999) (no discussion of trilogy); *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436 (8th Cir. 1997); *Parrino v. FHP, Inc.*, 146 F.3d 699 (9th Cir. 1998).

of them even pre-date the *Travelers* trilogy, putting them roughly in the Pleistocene era of ERISA-preemption law; those three are *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270 (10th Cir. 1996); and *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995).)

In sum, the petitioners' claim of a "firmly entrenched" circuit split (Aetna Pet. at 28) is simply wrong. Three circuits—and three circuits only—have dealt, after *Pegram*, with whether an HMO's mixed eligibility and treatment decision takes a state medical-negligence claim out of ERISA's preemptive scope and leaves it to state law where health-care matters have traditionally been regulated. And those three circuits, the Fifth, Second, and Eleventh, have all agreed that *Pegram*'s teaching, viewed through the prism of *Pilot Life* and its progeny, warrants a conclusion that Congress did not intend to preempt state malpractice law and that a section 502(a)(1)(B) contract-based claim to "recover benefits" cannot be stretched to cover a tort claim of medical malpractice.

CONCLUSION

Because the decision below does not run afoul of this Court's precedent, and because no circuit split exists on the issue of section 502(a)(1)(B) complete preemption, the petitions should be denied. The appellate court correctly ruled that the district court lacked jurisdiction under 28 U.S.C. § 1331, and further review is therefore not warranted.

In the alternative, the petitions should be held pending the Court's consideration of the petition in *Roark v. Humana, Inc.*, No. 02-1826, for that case truly does involve a circuit split: though the Fifth Circuit in *Roark* (reluctantly) held that the plaintiff's medical-negligence claim under the Texas Health Care Liability Act was conflict preempted under ERISA § 514, the Second Circuit in *Cicio* held precisely the opposite in a case involving a New York medical-negligence claim. Because resolution of the broader section 514 "relates to" issue would of necessity resolve any section 502(a)(1)(B) complete-preemption issue as well, *Roark* would seem the case of greater importance to ERISA-preemption jurisprudence.

Respectfully submitted,

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